



Texas Department of Health

Bureau of Emergency Management

WALLET CARD REPLACEMENT APPLICATION

To request a duplicate EMS wallet card, submit completed form and payment to your local public regional office or mail in the preprinted envelope to:

Texas Department of Health
P O Box 149200
Austin, TX 78714-9200

For TDH Use Only **2A284/160**

Receipt # _____

Date _____

Amount _____

All information given on this application is considered public record, with exception of social security number*.

Requesting duplicate for the following level(s): <input type="checkbox"/> ECA <input type="checkbox"/> EMT <input type="checkbox"/> EMT-I <input type="checkbox"/> EMT-P <input type="checkbox"/> LIC-P <input type="checkbox"/> COORDINATOR <input type="checkbox"/> EMS INSTRUCTOR <input type="checkbox"/> EMD INSTRUCTOR							
I am: <input type="checkbox"/> Enclosing \$5.00 per level <input type="checkbox"/> EXEMPT from fee - Complete Volunteer Sign-Off below							
*Disclosure of your social security number is voluntary. We recommend you provide your social security number to be used as a unique identifier so as to prevent confusion among applicants of similar or same name.							
Last Name First Middle PRINT:						Social Security* or Texas EMS ID:	
MAILING ADDRESS:		PO Box or Street	Apt #	City	County	State	Zip
Birth Date (MM/DD/YY):				Home Phone: ()		Work Phone: ()	
Are you associated with an EMS Provider or 1st Responder? <input type="checkbox"/> No or <input type="checkbox"/> Yes, Continue L <input type="checkbox"/> Salaried - Employment Date: <input type="checkbox"/> Volunteer - Complete Volunteer Sign-Off section below							
SIGNATURE:				DATE:			

Volunteer Sign-Off Section - complete if applicable

This section to be completed by EMS provider or FRO administrator This candidate is exempt from the payment of fees because he/she actively provides emergency medical care for our organization, which is a TDH licensed emergency medical services provider or a TDH registered first responder organization, and does not receive compensation** for providing these services. Additionally, to the best of my knowledge, this candidate does not provide emergency care for any other organization in return for compensation**, other than reimbursement as described below. I have explained to the candidate that if during the certification period, the candidate begins to receive compensation**, for providing emergency medical services, from any organization, the exemption is inapplicable and the candidate shall send to the department an application and a prorated fee.	
Signature of Administrator	Printed signed name
** Compensation does not include reimbursement for actual expenses for medical supplies, gasoline, clothing, meals and insurance incurred while volunteering.	
FIRM/ORGANIZATION NAME:	
TDH FIRM/REGISTRATION NUMBER:	PHONE:

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.tdh.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 522.021, 522.023 and 559.004)